Report on the Outcome of the Integrated Inspection of Safeguarding and Looked After Children's Services in Leicestershire

Date of Inspection	**19th March 2012 – 30th March 2012**
Date of final Report	**14th May 2012**
Commissioning PCT	**NHS Leicester, Leicestershire and Rutland Cluster**
CQC Inspector name	**Tina Welford**
Provider Services Included:	**University Hospitals of Leicester NHS Trust** **Leicestershire Partnership NHS Trust**

This report relates to the recent integrated inspection of safeguarding and services for looked after children which took place in the above Authority recently

It provides more detailed evidence and feedback on the findings from the Care Quality Commission's (CQC) component of the inspection, and links these to the outcomes requirements as set out in the Essential Standards for Quality and Safety.

Thank you for your contribution to the inspection and for accommodating the requests for interviews and focus groups with your staff and those of partner agencies at relatively short notice.

The team provided feedback to your local Director of Children's Services at the end of fieldwork and the joint inspection report to the authority is now published on the Ofsted website and can be accessed via this link: The joint inspection report .

NHS Leicester, Leicestershire and Rutland Cluster	
Safeguarding Inspection Outcome	**Aggregated inspection finding**
Overall effectiveness of the safeguarding services	Adequate
Capacity for improvement	Good
Contribution of health agencies to keeping children and young people safe	Adequate
Looked After children Inspection Outcome	**Aggregated inspection finding**
Overall effectiveness of services for looked after children and young people	Good
Capacity for improvement of the council and its partners	Good
Being healthy	Outstanding

This report includes findings from the overall inspection report, and provides greater detail about what we found, mapped where relevant to the Essential Standards, in order that your organisation can consider and act upon the specific issues raised.

A copy of this report is being sent to your commissioning PCT, and CQC Regional Director. This report is also being copied to the Strategic Health Authority/Monitor as appropriate and CQC's regional director, who has overall responsibility for this inspection programme.

*In respect of the recommendations in the report, please complete an action plan detailing how they will be addressed and submit this to CQC and your SHA Chief Executive within **20 working days** of receipt of the final report.*

The Inspection Process

This inspection was conducted alongside the Ofsted-led programme of children's services inspections. These focus on safeguarding and the care of looked after children within a specific local authority. The two-week inspection process comprises a range of methods for gathering information – document reviews, interviews, focus groups (including where possible with children and young people) and visits – in order to develop a corroborated set of evidence which contributes to the overall framework for the integrated inspection.

CQC contributes to the inspection team and assesses the contribution of health services to safeguarding and the care of Looked after children relating to that authority. Our findings from the inspection contribute to the joint report published by Ofsted and also enrich the information we use to assess providers against the Essential Standards of Quality and Safety. This report sets out specifically the evidence we obtained in relation to these standards and extracts from the published report are included and identified.

CQC used a range of documentary evidence in advance of and during this inspection, and interviewed individuals and focus groups of selected staff and, where possible, children and young people, their parents and carers in order to provide a robust basis for the findings and recommendations.

This document sets out the findings in relation to the organisations listed above, but includes some areas which apply to one or more other NHS bodies where pertinent.

Context:

Commissioning and planning of child and young peoples' health services, including primary care are undertaken by NHS Leicester, Leicestershire and Rutland (LLR) PCT Cluster. Universal, targeted and specialist services such as health visiting, school nursing, paediatric therapies, safeguarding, looked after children and community nursing is delivered primarily by Leicestershire Partnership NHS Trust (LPT).

The main provider of all acute hospital services for maternity, children and young people is University Hospitals of Leicester NHS Trust (UHL); this includes an acute assessment and children's accident and emergency services.

Children and families access primary care services through one of the 84 general practitioner practices, two walk in centres, and/or the urgent treatment centre / minor injury centre, located on the University Hospitals of Leicester NHS Trust Site, which is provided by George Eliot NHS Trust.

Community-based child and adolescent mental health services (CAMHs) and in-patient CAMHs, located at Oakham House, are both provided by Leicestershire Partnership NHS Trust. For children with learning disabilities and difficulties and who have complex health needs services are provided by Leicestershire Partnership Trust. These services are commissioned through a multi agency partnership and have a specific commissioner who covers LLR.

The NHS Leicester, Leicestershire and Rutland (LLR) PCT cluster employs a senior doctor and nurse to undertake the designated safeguarding functions in line with statutory requirements. Both Leicestershire Partnership Trust and University Hospitals of Leicester NHS Trust have internal safeguarding services employing named nurses, named doctors and a named midwife, as well as a number of other specialist nursing posts to support safeguarding.

There is a designated nurse for Looked After Children, a designated doctor has been appointed and will commence from 1 April 2012, and a named doctor (GP) for Looked After Children, employed through Leicester Partnership Trust. The looked after children's health services are commissioned jointly across Leicester, Leicestershire & Rutland. There is a dedicated team that links with the social care teams with each the local authority.

Leicestershire County and Rutland have a joint funded post leading the joint strategic commissioning for the local authority and health. This role, along with a well integrated public health function, has bought planning and delivery closer together. Shared priorities have been agreed, service delivery via changes to specifications has taken place and a more consistent approach for parents, carers and children and young people has been achieved.

General – leadership and management

1. Joint and integrated commissioning is developing well. The Health and Well Being Board development is well underway. Partnership working is a strength with increasing closer working with the Director of Children and Young People, exemplified within the recently revised Joint Strategic Needs Analysis (JSNA) which also contains specific reference to looked after children (LAC) health outcomes.

2. There is good senior manager and executive level partnership working and engagement with the local safeguarding childrens board (LSCB). The two clinical commissioning groups (CCGs) are well engaged with the emerging safeguarding children agenda, and have secured representation on the LSCB. Safeguarding policies and training strategies have been reviewed and reflect current guidance. There is effective learning from serious case reviews, significant incidents and individual management reviews. Good use is made of the outcomes from the Section 11 safeguarding audits, showing good levels of compliance, with regularly monitored action plans through individual NHS trust safeguarding governance structures.

3. The designated nurse for looked after children is highly visible and has strong partnerships and engagement with all health partners and the senior leadership teams in children and young people's social care. There is good engagement at strategic level with the Corporate Parenting Board and the Health and Well Being Strategic Looked after Children Group, both of which hold the looked after children health team to account through robust challenge.

Outcome 1 Involving Users

4. Looked after young people are positive about their health, reporting that the health assessments/reviews are 'helping them to improve and take responsibility for their own health'. Looked after young people views and contributions are being sought to further develop the range of age appropriate health promotion information.

5. The child and mental health service (CAMHS) have gained the You're Welcome Quality Criteria for Young People Friendly Health Services.

6. There is good access to interpretation and translation services for all health staff and good access to telephone interpretation services in emergency health care settings.

Outcome 2 Consent

7. Consent is sought before all looked after children and young people have their health assessment/review. Accident and emergency services (A&E) at University Hospitals of Leicester (UHL) processes for ascertaining who has parental consent are not robust.

Outcome 4 Care and welfare of people who use services

8. The Every Child Matters outcome 'Being Healthy' is judged as *Outstanding*.

9. All looked after children (LAC) health assessments/reviews are subject to rigorous quantitative and qualitative review. The designated nurse is part of the Department of Health quality standards group for initial health assessments and as such is using learning from this group to improve further the locally provided service.

10. All health assessments/reviews seen, had effectively used the emotional health assessment screening tool, with some files containing the strength and difficulties questionnaire (SDQ) score as well. Outcome data shows that immunisation rates are between 88%-100% depending on the type of immunisation. The dental assessment rate is 90% and the health assessment/review rate is 93%, all of which are above England averages. The authority-wide SDQ score is higher than the England average at 17.5 (England 13.9), representing the 456 looked after children, but there is good use of emotional health services with 79 looked after children and young people receiving CAMHS interventions.

11. There is a dedicated looked after children, child and mental health service (CAMHS) team, which is accessed through the CAMHS 'single point of access', which is effective, resulting in prompt consultation and assessment of need. Waiting list and 'time to treat' waits are in line with national targets. Good use made of the CAMHS looked after chidlren team telephone consultation and advice services prior to referrals being made. In some cases the telephone consultation acts as the referral, reducing delays and duplication. There is good communication and partnership working between the looked after children CAMHS team, the LAC specialist nursing team and social care managers, providing an ongoing record of interventions. This information is effectively used in the next health assessments; however, information sharing is not replicated with community practitioners. The CAMH team provides a good range of training and support for foster carers, for example, the highly valued attachment disorders training.

12. The looked after children specialist nurses provide good support to the 'hard to engage' looked after young people, flexibly delivering services, for example, meeting young people in their residential care home settings over dinner and informally discussing their concerns and gaining therapeutic trust for more focussed treatments to commence.

13. The looked after children specialist nurses ensure that all care leavers are supported and registered with primary health services, providing on going 'after care' support as required. Working in partnership with the looked after children social worker, care leavers are provided with health history information as part of their care leaving information pack. Care leavers and all looked after young people do have a copy of the 'Clayton File' which contains health education/information and details of their immunisation status, which is shared and discussed at each of their health assessments and reviews. Birth history is shared where there has been birth parent consent.

14. The core CAMH service is accessed through a ‘single point of access’, resulting in prompt consultation and assessment of need. Those young people in ‘crisis’ or self harming when referrals are received these are appropriately prioritised by the on-call services, which is predominately staffed by trained CAMH staff, however, there are occasions when adult mental health registrars staff the rota overnight, causing delays in the young person receiving specialist advice. Following a number of waiting list initiative clinics the core CAMHS waiting list and time to treatment are in line with national targets but caseloads are now reaching, and in some cases are over, capacity.

15. There is generally good access to the county ‘very specialist services’ beds (Tier4) for those young people aged between 11 and 18 years. Access for younger children is less robust. However, during the inspection occupancy rates were over 100%, as ‘leave’ beds were being used to accommodate new admissions, health staff report that it is not unusual to use the ‘leave bed’ is this way. Consequently, if the young person on leave returns earlier than planned, their bed is not available. Good use is made of the care programme approach (CPA) which ensures that ‘on admission’, discharge planning is commenced. There is good support provided for the parents/carers of young people with good links with the family therapy services.

16. The established family therapy services only employs a small number of therapists who hold a number of clinics supporting the specialist and very specialist services (tier 3 and 4), which are highly valued. The service has good links with children and young people’s social care. However, due to the limited capacity of the family therapy service, staff are often unable to act as an advocate for the young people, thereby restricting the voice of the child, and attend the various social care and multi professional meetings.

17. Those children and young people (up to the age of 18 years) who have a mental health concern and a learning difficulty or disability are able to access a dedicated CAMHS service. This service includes those young people with behavioural and sleep disorders. There is good targeted intervention provided for parents and foster carers with a ‘care pack’ developed to meet the individual child/young person’s needs. This dedicated service provides valued support for young people if they are admitted to the very specialist service inpatient beds (tier 4) and supports them through the discharge process and when they return home, through effective outreach services. This dedicated support enables quicker discharges and has reduced the length of hospital admission. An effective outreach service is provided through a range of interventions including day care services for those young people with behavioural needs and out of area placed looked after young people. There is good engagement with the special schools, once notified, with mental health staff attending the review meetings. There is a successful process in place for young people and their carers to re-refer to the service or request a consultation appointment once discharged.

18. There still remains a lack of service provision and effective transition arrangements for those young people with behavioural difficulties and those with mild learning disabilities and difficulties. This area is still to be addressed from a recommendation from a previous Integrated Inspection of Safeguarding and Looked After Children’s Services in Leicester City.

19. As a result of a serious case review self harm pathways, have improved with better communication and ongoing feedback from CAMHS regarding the care being provided to the young person. When a young person, 15 years or under, is admitted following a self harming incident, they are admitted to the paediatric wards, if over 16 years they are admitted to adult wards, irrespective of whether they are in education, or following little choice or consultation with the young person. There are delays in obtaining a child mental health assessments prior to discharge, from Friday (after 5.00pm) until Monday late afternoon (or next working day if a bank holiday) resulting in some young people remaining inappropriately in hospital or self discharging. Those that have self discharged have an out-patient follow-up appointment with CAMHS. There is an improving awareness of parental and adult mental health issues and the impact on the health and well being of the young person.

20. The substance misuse and alcohol service, Swanswell, has only been in place since December 2011 and not yet up to full staffing establishment. The services are targeted at the 11-18 years old group and delivered through a flexible outreach model in non clinical settings. Very early evaluation has already demonstrated positive outcomes for the service users. Swanswell is establishing partnership arrangements with the local police, other health organisations, youth offending teams, and social care. Links with the safer community and children sexual exploitation workers are still developing. The service has provided an adequate range of education and health promotion workshops within schools and for staff working in a range of organisations, who provide services for substance misusing parents, to identify young carers and their needs and ensure that they are protected from harm. Swanswell staff, as a result of CAF training, are now confident to initiate a CAF, although yet to do so.

21. In the Loughborough area looked after pregnant young women, their partners and young families with babies up to two years old, and who have complex needs are now able to access a dedicated ‘Early Start’ health visitor led project. It is too early to measure the impact of this project however, early anecdotal feedback from professional and service users has been positive. Those looked after children living elsewhere in the county have good access to sexual health advice and if they become pregnant, are well supported throughout the pregnancy and post-natally by both the looked after children nursing team and the teenage pregnancy specialist midwife and other maternity services. Those that decide to terminate their pregnancy are well supported.

Outcome 6 Co-operating with others

22. The health professionals working with children who have disabilities and life limiting conditions use a holistic needs assessment approach, which has improved communication with other health practitioners. Further, this approach has enabled the review of caseloads and practitioners receive, through supportive supervision, good challenge of care programmes. Engagement with special schools is variable; the speech and language services, in consultation with head teachers and parents, are reviewing their delivery models at the time of the inspection with the aim of improving further the levels of engagement.

23. Transition remains an ongoing concern for parents due to the different adult services structures, which are hard to navigate. Young adults from the age 17½ years are well supported during transition to adult mental health services through joint case working. Those looked after young people who have Attention Deficit Hyperactivity Disorders or those on the autistic spectrum, have dedicated services to support them. However, there are delays in transition due to the lack of a suitable young person placements being arranged by social care. When delays occur, CAMHS will retain the young person on their caseload, providing a stabilizing influence until they are in a new stable placement.

24. The Diana Nurses provide a highly valued flexible service to children, their siblings and families. Through the joint work with the bereavement therapists and counsellors there is good ongoing bereavement support, starting at the time of diagnosis for all the family members and carers and continuing after the child has died.

25. There is a good range of highly valued training for foster carers and new adoptee parents which is responsive to their needs and helping to prevent placement breakdown. A range of good structured or individualised training programmes are also provided to staff in all the residential children homes.

26. The teenage conception rates are 33.3/1000 under 18 year olds, which is lower than the England averages (March 2011). There is good partnership working resulting in targeted attention being given to the teenage pregnancy hotspot areas especially by community practitioners and the teenage pregnancy specialist midwives. There are easily accessible young person sexual health clinics throughout the county, with additional ‘drop- in’ clinics provided during the school holiday times in a range of flexible locations, including parks. Within some areas of the county there is good access to young parent programmes, such as ‘Baby Steps’ and ‘Next Steps’. These have resulted in additional support to young parents and in some cases young parents reengaging with education services. For those young mothers-to-be who access health services in the south of Leicestershire and the north of Northamptonshire, there are effective support systems in place across the boundaries, which include support from the sure start, home start services and the family outreach workers. These services, along with the education provision provided by school nurses for year 9 students, is helping reinforce the ‘delay messages’ reduction in second conception rates.

27. There are good referral pathways in place to the sexual assault referral centre and the genito-urinary medicine centre. Further, there is good access to confidential emergency contraception services. Maternity services provide a well coordinated approach to protecting the mother and unborn baby from harm. However, there still remain challenges in ensuring that social care staff arrange timely unborn baby case conferences, with some being held too late, for example, at 36 weeks gestation. Once birth plans are written these are effectively communicated. Social care staff do not always share with maternity staff the outcomes of meetings with the birth parents, especially when care proceeding papers are served. There are frequently delays with retrieval of the baby into foster care, notably when the baby is born on a Friday, resulting in unnecessary hospital stays for both the mother and the baby and increasing the safeguarding risks to the baby and the emotional trauma for the birth mother.

28. Baby mapping forms (based on body mapping forms) have been introduced for all babies where there are injures noted as part of the delivery or at birth. These forms are shared with A&E and other child health services where a baby under six months could be seen or admitted. The baby mapping forms identify known ‘marks’ to exclude them as potential non accidental injuries when undertaking a physical examination. The specialist safeguarding midwife reviews all baby records ensuring safeguarding concerns are identified; areas of concern are then discussed within supervision which is improving practice.

29. There is improving engagement of young mothers who are ‘hard to engage’ with contraceptive services, with some GPs now phoning the young mothers to arrange appointments. Although this is limited to only a few GPs, it is proving successful.

30. Some mothers reported that the ‘Mums in Mind’ group for those mothers suffering with postnatal depression is invaluable. The dedicated evening clinic to support fathers has also been positively evaluated. However, this service is not provided across the county, disadvantaging some families.

31. The dedicated health visitor for the travelling families has good partnership and engagement with the travelling community. By working with the young mothers, the women and their children are now regularly attending children centres and the health visitor ‘drop-in’ clinics.

32. The healthy child programme is delivered on a focussed needs based model, which reflects the reduced capacity of the health visiting service. There are only a very few drop-in clinics now being held, due to this limited capacity. Breast feeding groups are supported with early results showing that the previously reported low breastfeeding rates are starting to improve. There is good age appropriate health promotion and education provided for looked after children

33. The use of the common assessment framework (CAF) has been slow to commence as, staff state that there is already an embedded culture of partnership working, which they perceive is not enhanced by the use of a CAF. Team around the child and the team around the family meetings are viewed positively, quickly arranged (more so than a CAF meeting which takes six weeks) resulting in prompt action being taken to protect children and their families. The attendance of CAF meetings remains a challenge for community health practitioners, due to their limited capacity and high complex caseloads. However, for those staff working with children who have disabilities and life limiting conditions CAFs are positively viewed, when proactively used by all partner agencies, providing support and interventions for families and preventing safeguarding concerns escalating.

Outcome 7 Safeguarding

34. The contribution of health agencies to keeping children and young people safe is *adequate*.

35. There is good access to and a highly valued designated and named nursing safeguarding team, which is held to account in line with *Working Together to Safeguard Children* requirements. The designated and all named health professionals provide a good coordinated approach to safeguarding arrangements. Frontline practitioners have an understanding of safeguarding referral thresholds, the application of which have been standardised across the county since the introduction of the new central 'duty desk'. The recently introduced safeguarding health helpline is highly valued, and has assisted with the escalation of concerns. Some community health staff and staff who work with children who have disabilities and life limiting illnesses are not aware of the safeguarding referral escalation process, reporting that the family has to be in crisis before the referral is accepted. All health staff report that there is limited, and not always timely, feedback from social care on the status of referrals. The impact of the recently introduced 'signs of safety' as a methodology to enable better coordination across agencies for safeguarding thresholds is yet to be seen.

36. Accident and emergency services (A&E) at University Hospitals of Leicestershire (UHL) do not have a 'flagging' system. A&E staff contact the social care duty teams including the emergency duty team out of hours, however, the information they receive is very limited. There is a good process within the A&E department, to review all children between the ages of 1 and 2 years who have attended with a fracture. All cases are reviewed and quality control measures ensure that appropriate safeguarding referrals and measure have been put in place.

37. The unscheduled care setting (A&E, urgent care centre, and walk-in centres) notifications are distributed to community staff and to the dedicated safeguarding staff all of whom effectively followed up by the looked after children team, health visitors, school nurses or general practitioners, ensuring that enduring health needs are met. Loughborough walk in centre notifications contain no information as to the reason for attendance, which is preventing effective follow up.

38. There is a child death rapid response team as part of the child death overview panel (CDOP) processes, however, frontline practitioners were mostly unaware of this provision. There is little information shared by CDOP about their role of which that staff are aware, and little information of the impact of the campaigns to reduce child deaths. A project has recently commenced to reduce the number of babies/young children admitted with head injuries, with DVDs being shown to new parents post-natally and prior to discharge from maternity services but it is too early to measure the impact of this initiative.

39. There is very limited engagement from GPs with the safeguarding arrangements across the county, with a lack of performance monitoring of the safeguarding actions and outcomes within primary care settings. Following the transforming community services changes there has been a recognised cultural shift and alignment of responsibilities and the engagement with safeguarding and the child death overview panel process is evolving.

40. GP practice information management systems are able to 'flag' both children on a protection plan and those that are looked after, however commissioners are unaware how effectively this is used.

41. Those GPs interviewed, reported short notice to attend child protection conferences with a lack of flexibility of meetings times and venues to enable them to attend. School nurses report that they are not always invited to attend Section 47 and other chid protection meetings especially children in need meetings, which is a missed opportunity to share information and ensure children are protected from harm. There has been a lack of proactive action being taken to address this.

42. There is a valued dedicated health visitor for the homeless who also works with the women placed in the three refuges. The post holder has good networks and partnerships with other agencies, but challenges still remain with getting referrals accepted by social care. There is a lack of accommodation for those women who have a number of children or a son over the age of 13 years, often resulting in the woman and her children having to stay with relatives or returning to an abusive relationship restricting interventions that health staff can provide. There are support programmes provided for victims of domestic violence, increasing their self esteem.

43. There is good engagement and attendance at multi agency referral and assessment conferences (MARAC) although the contribution of the staff who attend is yet to be assessed. There recently revised domestic violence pathways and referral process has improved awareness of the potential range of perpetrators, increased referrals and pre birth conferences. Good attention is paid by midwives in ascertaining if there is domestic violence and protecting from harm the mother and unborn baby.

<u>Outcome 11 Safety, availability and suitability of equipment</u>

44. There is a dedicated childrens' A&E at University Hospitals of Leicestershire (UHL) for young people up to the age of 16 years.

45. Access to equipment for children and young people with disabilities is variable and challenging especially at transition times. There is pooled funding to improve access to the equipment but this has not yet been realised, with in some cases, a reported five month delay for assessments and a further wait for the equipment which, when it arrives, is often no longer suitable or the child has physically outgrown the equipment. Those older children with behavioural problems who require a buggy often experience long delays. When the equipment arrives there is no sun or rain protection, families have to purchase separately at significant cost, many of whom cannot afford to purchase, thereby restricting the times when the family are able to use the equipment, as a consequence increasing their social isolation.

Outcome 12 Staffing recruitment

46. All staff interviewed, during the inspection, with the exception of those employed by UHL, confirmed that they have had an enhanced criminal records bureau check (CRB) in the last 3 years.

Outcome 13 Staffing numbers

47. Childrens' A&E has appropriately qualified and trained staff on duty. Health visiting services have a small number of vacancies, (in health visiting 2.6 whole time equivalents (WTE) with 6 WTE in Leicestershire and Rutland) which have been frozen until those in Leicester City are filled, due to the migration out of the city to the county posts. There are no vacancies within the school nursing service although there has been some caseload management concerns, with practitioners reporting that they are still holding large complex caseloads, in some cases double the number of cases than they should be.

Outcome 14 Staffing support

48. All staff seen during the inspection confirmed that they were up to date with their safeguarding training and following the recent revision of the application process, courses are now easier to access. There is good access to thematic training such as fabricated illness and injury, and domestic violence. The impact of training on changing practice and ensuring that training is embedded into practice is less well developed. Access to safeguarding supervision is variable and infrequent depending on professional group. Designated staff have good access to effective supervision.

49. The primary care and clinical commissioning groups reporting and governance structures are just developing; with a nominated lead GP for safeguarding now appointed. Work streams and priorities have been identified which include a priority to improve the compliance rate with safeguarding children training for GPs and their practice staff, which is recognised as being only sufficient. Not all GPs are progressing towards level 3 safeguarding training. There is recognition by commissioners and the two CCG management teams, that training data cleansing is required, as data is not accurate and is out of date. The training compliance data provided for the inspection showed that in the East Leicestershire and Rutland clinical commissioning area (185 GPs) 83% are trained at level 2, and in the West Leicestershire the rate is 83% at level 2 (270 GPs). No data was available for other practice staff, or other primary care staff such as dentists.

50. At University Hospitals of Leicester NHS Trust training compliance rates are variable, trust wide the cumulative total is only just adequate at 80%. In the women and children division rates are 80% (76-80%), in the acute division only76%, planned care 65%, 79% in the clinical division and 61% in the corporate services, all of which are inadequate. At Leicestershire Partnership Trust the compliance rates are variable, level 1 is 94.1%, level 2 is 57.8% which is inadequate and level 3 is 85.9%. This was identified in the recent Leicester City safeguarding and looked after inspection and is yet to be fully addressed.

51. The A&E and Children Assessment Unit staff are not well supported following a child death in the department. The staff debriefing process is not comprehensive or robust. There is little use made of the confidential counselling helpline (AMICA, commissioned by Leicestershire Partnership Trust) and currently there is a long waiting list. This is being addressed by Leicestershire Partnership Trust.

52. Staff working in the substance misuse services, including those working in the youth offending service, have good access to supportive reflective practice sessions (supervision) when reviews of treatment interventions occur, ensuring that the most suitable intervention is being used.

53. Community practitioners and therapists have good access to safeguarding supervision and safeguarding training, although due to the limited capacity of some community team supervisors, it is not always possible to access supervision before a child protection conference in line with the trust policy.

54. There is a well established dedicated looked after children specialist nursing team, lead by a proactive designated nurse, who works in an open and transparent style, reporting and accountability structures are in line with statutory guidance. This approach is ensuring good engagement with all looked after children, including the out of area placed children and those placed in the 22 residential children homes within the county. There is frequent contact made with all the residential care homes which ensures that the needs of the children and young people are promptly identified, assessed and interventions put in place. The named doctor for looked after children ensures there is good support and training for paediatric registrars, who undertake the initial health assessments, which is maintaining a consistently high standard of holistic assessment.

55. All looked after children health staff (including the designated staff) have access to ongoing supervision, which is recorded on SystmOne alongside the child/young person's notes and the staff members continuing professional development records.

Outcome 16 Audit and monitoring

56. There is good monitoring of the looked after children outcomes by the Looked after Children Health and Wellbeing Strategic Group. Robust arrangements are now in place following the recent change in the initial health assessment (IHA) notification process and the six weekly follow up by the looked after children nurses of all new looked after children and their foster carers. There is at least a10% delay from social care in notify health of all new looked after children cases, which delays the initial health assessment. However, once notified all IHA are completed within four weeks of receiving the notification. The engagement with the independent reviewing officers (IROs) is too variable.

57. The use of SystmOne, the patient information management system, is viewed positively be community health practitioners and has helped with the collation of information for child protection reports. However, some of the processes are time consuming and act as 'blockers' to recording. For the therapy services the introduction of SystmOne has been reported as the most significant culture change in making safeguarding everyone's business, with better sharing of information and practitioners taking responsibility for safeguarding concerns and issues.

58. There is good use made of the Strategic Health Authority 'markers of good practice' for safeguarding, development is underway for the markers of good practice to be used in GP practices to provide assurance of quality and improve engagement within the safeguarding agendas

Outcome 20 Notification of other incidents

59. There is effective use of the local authority designated officer (LADO) role. There is good monitoring and evidence of changes as a result of significant incidents across most of the healthcare sector.

Outcome 21 Records

60. All the looked after children health records seen, including the health assessments and reviews, were of a good quality, comprehensive and action plans reflected the assessments; all but one action plan had appropriate timeframes. Recording complied with professional record keeping standards.

Recommendations

(Those from the joint report in italics) –

Within 3 months

NHS Leicester, Leicestershire and Rutland must ensure that general practitioners and those working in the primary care health sector are fully engaged with the local safeguarding arrangements, including being up to date with their safeguarding training, and in the case of all GPs hold level 3 safeguarding training compliance/competencies.

NHS Leicester, Leicestershire and Rutland and Leicestershire Safeguarding childrens board must ensure that all health staff especially those working with children who have disabilities, are made aware of how to escalate safeguarding concerns especially those relating to the referral process to children and young peoples' social care.

NHS Leicester, Leicestershire and Rutland must ensure that children with behavioural difficulties, and those with low level Attention Deficit Hyperactivity Disorders and those on the Autistic Spectrum, are enabled to access emotional well being services and supported through transitions to adult health and social care services.

Within 6 months

NHS Leicester, Leicestershire and Rutland must ensure that providers comply with safer recruitment procedures and that health staff are fit to practice and work within children and young people services

Next steps

An action plan is required from the commissioning PCT within 20 working days of receipt of this report. Please submit the action plan to your SHA copied to CQC through childrens-services-inspection@cqc.org.uk and it will be followed up through the regional team.